REFERRAL FOR ORAL APPLIANCE THERAPY CONSULTATION

Patient Name____ Date: ____________________

PHN____________________ Date of Birth________________

Pt Email______________________________

Pt Phone___________________ Pt Cell___________________ Pt other__________________________

Address____City________________ Postal Code________

Family Physician___________________________ Phone________________ Fax___________________

Dental Office_____________________________ Phone________________ Fax___________________

PLEASE Fax to 604-987-5336 or email to info@snoredentist.ca

Patient symptoms: __ snores __ High Blood Pressure __ A-Fib __ Fatigue __ Type II Diabetes

__ Witness Apneas __ Previous DX Sleep Apnea

__ Previous CPAP __ CPAP Intolerance

Referring Dentist Signature___________________________

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Office stamp

Dr. Sharnell Muir

Sleep Better Live Better

212-700 Marine Drive North Vancouver, BC V7M 1H3

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